

TWIN II

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02849

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Wicomico MARYLAND		b. STATE Md. b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Route 2 Box 248	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		3. NAME OF DECEASED (Type or print)	First Middle Last
5. SEX Male		6. COLOR OR RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20 1967	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Infant	
		11. BIRTHPLACE (County & State, or foreign country) Md.	
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Armstrong		14. MOTHER'S MAIDEN NAME Evelyn Schoolfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
		17. INFORMANT Evelyn S. Armstrong Pocomoke, Md.	
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Immaturity (Birth wt 760 gms) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH approx 5 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/20 , 19 67 to 2/20 , 19 67 , that (I) (we) last saw the deceased alive on 2/20 , 19 67 , and that death occurred at 5:30 M, from causes and on the date stated above.			
22a. SIGNATURE Alfred C Kolls		22b. DATE SIGNED 2/20/67	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-67	
		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Trinity Meth. Cem. New Church, Va.	
24. FUNERAL DIRECTOR		23d. LOCATION (City or Town) (County) (State) Pocomoke Wor. Md.	
		25a. REC'D BY REGISTRAR Charles J. Charles J. J.	
		25b. REGISTRAR'S SIGNATURE CHARLES J. CHARLES J. J.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and int any event, within 72 hours after death.

Baby I
02850

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02843

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Route 2 Box 248	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Girl	Last Armstrong
S. SEX FEMALE	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY Infant	11. BIRTHPLACE (County & State, or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Armstrong	14. MOTHER'S MAIDEN NAME Evelyn Schoolfield		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Evelyn S. Armstrong Pocomoke, Md.	Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity (Birth wt 650 gms) 776X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____		INTERVAL BETWEEN ONSET AND DEATH approx 3 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/20 , 1967, to 2/20 , 1967, that (I) (we) last saw the deceased alive on 2/20 , 1967 and that death occurred at 752 M, from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE Alfred Geller		22b. DATE SIGNED 2/28/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-67	23c. NAME OF CEMETERY OR CREMATORIAL Trinity Meth. Cem. Pocomoke
24. FUNERAL DIRECTOR Samuel Lany New Church, Va.		ADDRESS 7-230173	25a. RECEIVED BY REGISTRAR DATE FEB 24 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02851

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wisconsin		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wisconsin		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Fruitland		d. STREET ADDRESS Morris Avenue Peninsula General Hospital		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
Female NEGRO				Ayres	February	27	1967	
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Female		NEGRO			February 27 1917	2	2	30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland		
13. FATHER'S NAME Isaac Ayres			14. MOTHER'S MAIDEN NAME Boulah			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.			17. INFORMANT Boulah Ayres Fruitland Md.		
Address								
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Immaturity - 465 gms</u> DUE TO 776X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <u>Premature</u> DUE TO stating the underlying cause (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <u>808</u> M, fram causes and an the date stated above.								
22a. SIGNATURE <u>William C. Morgan</u>								
22b. DATE SIGNED								
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/4/1967	23c. NAME OF CEMETERY OR CREMATORIAL Church			23d. LOCATION (City or Town) (County) (State) Tayler Gate Md.		
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u>		ADDRESS Salisbury - Md.		25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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02852

CERTIFICATE OF DEATH

02844

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 305 East 4th Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Alfred	Middle John	Last Baily	4. DATE OF DEATH February 14 1967	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1913	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10b. KIND OF BUSINESS OR INDUSTRY Penna. R.R.			11. BIRTHPLACE (County & State, or foreign country) Laurel, Delaware		
13. FATHER'S NAME John Baily			14. MOTHER'S MAIDEN NAME Sallie Nichols			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 221-09-4350			17. INFORMANT Mrs. Grace D. Bailey, Laurel, Delaware		
Address 305 East 4th Street								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus suspected. INTERVAL BETWEEN ONSET AND DEATH 466 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebitthrombosis site undetermined ? (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) D Cancer of Stomach & pulm. metastasis (2) Rheumatic arthritis								
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 02-18 , 19 67 , to 02-14 , 19 67 , that (I) (we) last saw the deceased alive on 02-14 19 67 , and that death occurred at 5th M, fram causes and an the date stated above.								
22a. SIGNATURE Joseph C. Fitzgerald		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-14-67
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-16-67		23c. NAME OF CEMETERY OR CREMATORIAL Junior Order Cemetery			23d. LOCATION (City or Town) (County) (State) Near Preston, Maryland	
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.		ADDRESS		25a. REC'D BY REGISTRAR FEE 20 1967		25b. REGISTRAR'S SIGNATURE James Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02853

CERTIFICATE OF DEATH

02845

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville 22-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Wesley BAKER		First	Middle	Lost	4. DATE OF DEATH February 24	Month	Doy Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH Dec. 31, 1890	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Dows Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Truck		11. BIRTHPLACE (County & State, or foreign country) Wicomico-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Slidell Baker				14. MOTHER'S MAIDEN NAME Anna Jane Donaway			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-7691		17. INFORMANT Everett Baker		Address Pittsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Acute pulmonary edema. 4200				INTERVAL BETWEEN ONSET AND DEATH 2 hours			
DUE TO (b) Arteriosclerotic Heart Disease				7 years			
DUE TO (c) Bronchopneumonia				10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 13, 1967, to February 24, 1967, that (I) (we) last saw the deceased alive on February 24, 1967, and that death occurred at 11:50 AM, from causes and on the date stated above.							
22a. SIGNATURE C.H. Winnacott				22b. DATE SIGNED 2/24/67			
22c. PHYSICIAN'S NAME (Type) Dr. C. H. Winnacott				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/26/1967		23c. NAME OF CEMETERY OR CREMATORIALY Grace Cemetery		23d. LOCATION (City or Town) (County) (State) Pittsville, Maryland	
24. FUNERAL DIRECTOR ADDRESS George Clegg - Salisbury, Md.				25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE FEB 28 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02854

CERTIFICATE OF DEATH

02846

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland		c. LENGTH OF STAY IN lb 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville 17.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Luther Middle Thomas Lost Baxter		4. DATE OF DEATH Month Feb. Day 26 Year 1967					
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 27-1887	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Dofs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Baxter		14. MOTHER'S MAIDEN NAME Wilhelmina Frampton		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 318-12-1002A		17. INFORMANT Mrs. John Nash--Chester, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure				INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Broncho - Pn.				10-1/4 days			
(c) Arteriosclerotic Heart Disease				--			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Cerebral Thrombosis with right Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 24, 1967, to Feb. 26, 1967, that (I) (we) last saw the deceased alive on Feb. 26, 1967, and that death occurred at 9 A.M. from causes and on the date stated above.							
22a. SIGNATURE C. H. Winnacott, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-26-67			
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M.D.		22d. ADDRESS Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF Feb. 28	23c. NAME OF CEMETERY OR CREMATORIES Stevensville	23d. LOCATION (City or Town) (County) (State) Stevensville, Md.			
24. FUNERAL DIRECTOR Edgar L. Lane Church Hill Md.		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge		
				DATE MAR 3 1967			

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CONFIDENTIAL

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CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02855

CERTIFICATE OF DEATH

02847

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 3 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 306 N. Div. St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAUDE	Middle JULIA	Lost 4. DATE OF DEATH FEBRUARY 2 1967
S. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6/26/1893	9. AGE (In years less birthday) 75 yrs.	10. KIND OF BUSINESS OR INDUSTRY Sales Lady	11. BIRTHPLACE (County & State, or foreign country) N.C.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 212-03-0907	17. INFORMANT Mr. E.R. White Jr. Park Ave. Salisbury, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure			INTERVAL BETWEEN ONSET AND DEATH
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (b) Hypertensive Cardiovascular Disease.			Years
DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular Accident			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from January 16, 1967 to February 2, 1967 , that (I) (we) last saw the deceased alive on February 1, 1967 , and that death occurred at 539 M, from causes and on the date stated above.			
22a. SIGNATURE Thomas P. Bigbee		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Feb. 2, 1967
22c. PHYSICIAN'S NAME (Type) Dr. Thomas P. Bigbee		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-5-1967	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Episcopal Cem.	23d. LOCATION (City or Town) (County) (State) Pocomoke, Maryland
24. FUNERAL DIRECTOR Hills Funeral Home Salisbury, Maryland		ADDRESS Norman J. Johnson	25a. REC'D BY REGISTRAR FEB 7 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

PARSO

1900-30 STADIUM

1930

COLISEUM

VISITATION

Legis. forces extension

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02856

CERTIFICATE OF DEATH

02848

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Lane, Fruitland 221			
c. LENGTH OF STAY IN lb				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First James	Middle Bivans	4. DATE OF DEATH Month FEBRUARY Day 12 Year 1967			
5. SEX MALE		6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2 1895	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (County & State, or foreign country) Pocomoke Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME SARAH HUTT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Phillip Hutt - Cedar Lane Fruitland, Md. Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident			DUE TO (b) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 Days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X			DUE TO (c)		Unk.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) St. Marys (County) St. Marys Co., Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/11 , 19 67 , to 2/12 , 19 67 , that (I) (we) last saw the deceased alive on 2/12 , 19 67 , and that death occurred on 2/12 , 19 67 , M, from causes and on the date stated above.							
22a. SIGNATURE George H. Henning				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) George H. Henning				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-67		23c. NAME OF CEMETERY OR CREMATORIAL St. Marys		23d. LOCATION (City or Town), (County), (State) St. Paul Office, St. Marys, Md.	
24. FUNERAL DIRECTOR Gretta S. Jolley - Jersey Rd Et 23 Salisbury, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
BP				DATE FEB 23 1967			

20850

1945-1946

02320

coincide

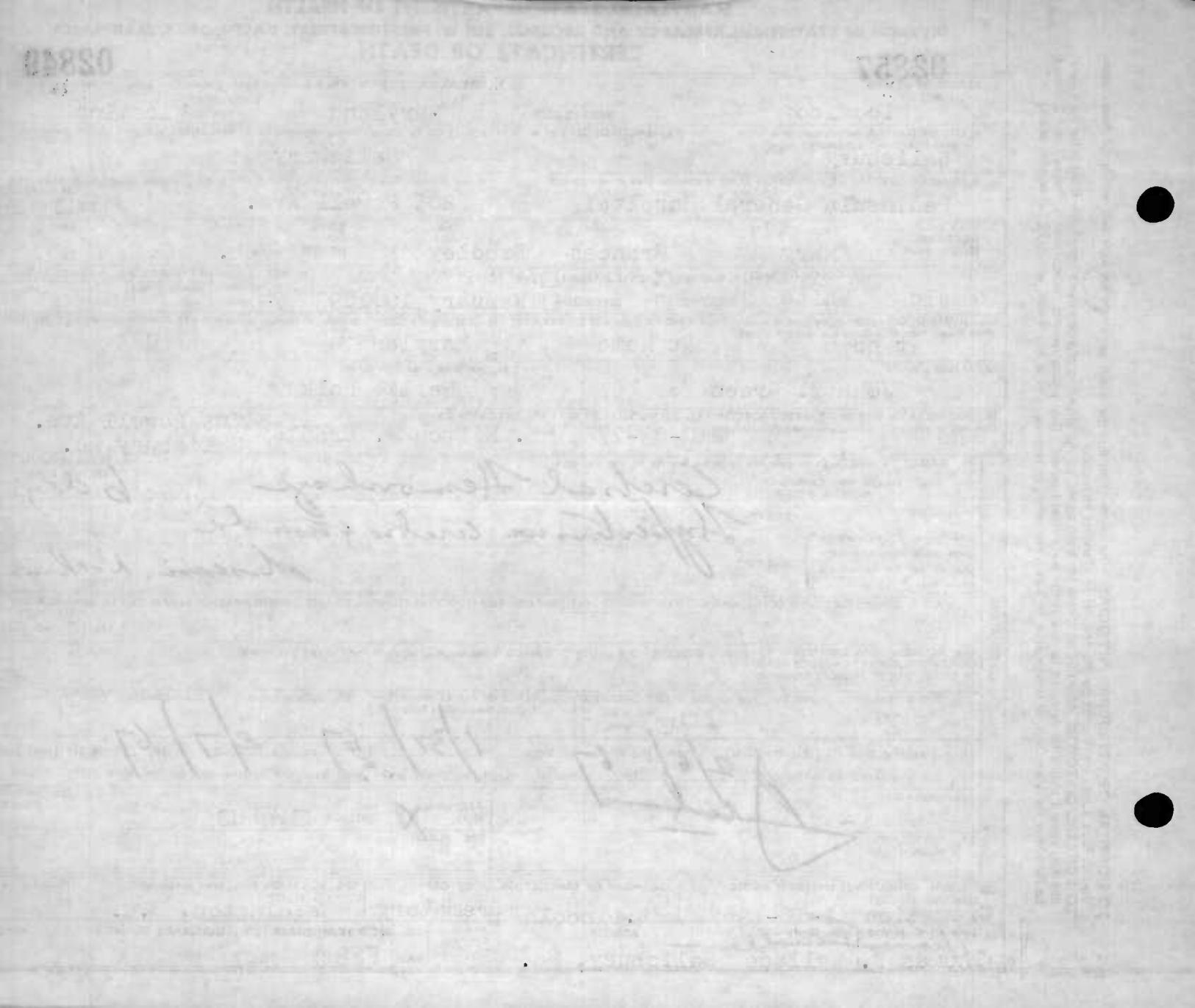
vacation

imperial German Holiday

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		02849	
02857															
1. PLACE OF DEATH a. COUNTY			Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)			a. STATE Maryland			b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			Peninsula General Hospital						d. STREET ADDRESS			205 Powell Ave.			
3. NAME OF DECEASED (Type or print)			First Mary	Middle Frances	Last Bradley				4. DATE OF DEATH	Feb. 7,	Month 1967	Dey	Year		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last, birthday)	10. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	January 10, 1893	74 yrs.	at home			Maryland	USA					
13. FATHER'S NAME			John T. Green			14. MOTHER'S MAIDEN NAME			Sallie Polk						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or date of service			no			16. SOCIAL SECURITY NO.			17. INFORMANT	Address 205 Powell Ave. Salisbury, Md.					
						217-03-7744			Mr. Milton A. Bradley						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 6 days						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			33IX			Hyper tension or cerebro vascular disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			(b)			(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
19						1/31/67			1967 to 2/7/67						
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____ and that death occurred at _____ A.M. from the causes and on the date stated above.															
22e. SIGNATURE						M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)									22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county) (State)						
Cremation			2/10/1967			Ft. Lincoln Crematory			Washington, D.C.						
24 FUNERAL DIRECTOR'S SIGNATURE			ADDRESS						25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
Thomas F. Wallace			Salisbury, Md.						DATE FEB 9 1967						
VR AIS (4) 20M 5-63															



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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02858

CERTIFICATE OF DEATH

02850

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hallwood 83-3	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mariue	Middle Reed	Last Bull
4. DATE OF DEATH	Month February	Day 22	Year 1967
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 20, 1894
9. AGE (In years last birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Michael	11. BIRTHPLACE (County & State, or foreign country) Nelsonia - Va	12. CITIZEN OF WHAT COUNTRY? M.S.A.
13. FATHER'S NAME William J. Bull.	14. MOTHER'S MAIDEN NAME Patty T. Baker.	Address Hallwood Va	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 225-01-7021	17. INFORMANT Mrs Mariue Bull	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Part operatn Surgery on oral Cruity INTERVAL BETWEEN ONSET AND DEATH Weeks 1600 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) because of Cancerina Throat Aspiration (c) Post op
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) Horsey (County) Va (State) VA		21. I certify that (I) (this hospital) attended the deceased from 9/22 , 19 67 to 9/26 , 19 67 , that (I) (we) last saw the deceased alive on 9/22 , 19 67 , and that death occurred at Horsey , 19 67 M, from causes and on the date stated above.	
22a. SIGNATURE Donald F. Fletcher Jr.		22b. DATE SIGNED 2/24/67	
22c. PHYSICIAN'S NAME (Type) Donald F. Fletcher Jr.		22d. ADDRESS Horsey, Va	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 2/24/67	23c. NAME OF CEMETERY OR CREMATORIAL Messells	23d. LOCATION (City or Town) Means (County) Va (State) Va
24. FUNERAL DIRECTOR Richard Johnson	ADDRESS Parkley, Va.	25a. REC'D BY REGISTRAR J Charles Judge	25b. REGISTRAR'S SIGNATURE
VR A15 (4) 20 M 1/66		DATE FEB 28 1967	

03830

1960-10-200-4185

22380

181 05 133

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02859

CERTIFICATE OF DEATH

02851

1. PLACE OF DEATH

a. COUNTY

Kentucky

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Delmar

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

RFD 3

**3. NAME OF DECEASED
(Type or print)**

First

Middle

Last

William

ISAAC

Calloway

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

4. DATE OF DEATH

Month

Day

Year

Sept

3

1967

8. DATE OF BIRTH

Aug 30 1896

9. AGE (In years
(last birthday))

70 yrs.

IF UNDER 1 YEAR

Months

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired trainman Penn. R.R.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Isaac Merrill Calloway

14. MOTHER'S MAIDEN NAME

Mary Virginia Phillips

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

Yes

WW I

16. SOCIAL SECURITY NO.

717-07-8296

17. INFORMANT

Martha Calloway Delmar Md

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

**PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)**

331X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cerebral vascular accident

INTERVAL BETWEEN
ONSET AND DEATH

1 week

Cerebral arterosclerosis, encaphalopathy 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

aspiration pneumonia

19. WAS AUTOPSY PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

1950 19, to Feb 3, 1967, that (I) (we) last saw the deceased alive on Feb 2, 1967, and that death occurred at 7 P.M. from the causes and on the date stated above.

22e. SIGNATURE

S. L. Sohler
L. V. Sohler

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

Delmar, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

2/6/67

23c. NAME OF CEMETERY OR CREMATORIUM

St Stephens

23d. LOCATION (City, town or county)

Delmar

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Marvin Funeral Home

ADDRESS

Delmar Del

25a. REC'D BY REGISTRAR

FEB 7

25b. REGISTRAR'S SIGNATURE

J Charles Judge

12850

STATE OF NEW YORK

12850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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02860

CERTIFICATE OF DEATH

02852

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Wicomico MARYLAND		b. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS 726 westover Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Edward Middle Saul Last Collins		4. DATE OF DEATH Month February Day 17 Year 1967	
3. NAME OF DECEASED First Edward Middle Saul Last Collins		4. DATE OF DEATH Month February Day 17 Year 1967	
5. SEX Male NEGRO		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 11-14-1893	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		11. BIRTHPLACE (County & State, or foreign country) Snow Hill, Md	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Milbourne		14. MOTHER'S MAIDEN NAME Sarah Collins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
		HAURA COLLINS. 726 Westover Dr. Salisbury	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221		Cordio-Vascular Disease	
DUE TO		Stroke	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		Myocarditis	
DUE TO		Unknown	
(c)		—	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Acute Asthmatic Bronchitis, Emphysema		—	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19		January 17, 1967	
21. I certify that (I) (this hospital) attended the deceased from January 17, 1967 to January 17, 1967, that (I) (we) last saw the deceased alive on January 17, 1967, and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
22e. SIGNATURE G. Herbert Sembley		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) G. Herbert Sembley MD		22d. ADDRESS Salisbury Ned	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-67	
23c. NAME OF CEMETERY OR CREMATORIAL M.L. Zion		23d. LOCATION (City, town or county) 2188 (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Loretta B. Jolley Jersey Rd #2		ADDRESS	
24. FUNERAL DIRECTOR'S SIGNATURE Loretta B. Jolley Jersey Rd #2		25a. REC'D BY REGISTRAR DATE FEB 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

82891

ST 90 TO 100 FT

02881

soil series

brownish

yellowish

soil series 182

soil horizons

27 EPI - 45-50 cm

28 H brownish yellowish

yellowish

soil (A) yellow

29 C - brownish yellowish

No. 82891 11. House

soil series 182

Feb 8 9 1974

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02853

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS Richardson's Labor Camp	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GERTRUDE	Middle L	4. DATE OF DEATH Month 2-7-67
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Mar 5, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY LABORER	9. AGE (In years lost birthday) yrs. 61
10c. MOTHER'S NAME SUE JENNETT		11. BIRTHPLACE (State or foreign country) N.C.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 031-10-0610	17. INFORMANT James Collins Pittsville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO 491X		INTERVAL BETWEEN ONSET AND DEATH days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)			
DUE TO lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED February 7, 1967	
ACTUAL SIGNATURE <i>Earl L. Royer, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1109 Camden Ave., Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/67	23c. NAME OF CEMETERY OR CREMATORIAL Glass-Bell
24. FUNERAL-DIRECTOR West		ADDRESS Mr. Bone, Salisbury	25a. LOCATION (City or Town) (County) (State) Person's Lig. Md.
		25b. REC'D BY REGISTRAR DATE MAR 7 1967	25c. REGISTRAR'S SIGNATURE Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02862		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						02854							
1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 409 Lake St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital															
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle STANLEY	Last COOK	4. DATE OF DEATH 2-3-67	Month	Day	Year 19							
5. SEX M	6. COLOR OR RACE AA	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17-1903	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Wetipquin		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Joseph J. Cook		14. MOTHER'S MAIDEN NAME mary Frances Redell													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 107-143539		17. INFORMANT Robinson Edward Cook		Address 110 S. Main St- Salisbury									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia				INTERVAL BETWEEN ONSET AND DEATH days									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) _____				(c) _____									
DUE TO															
DUE TO															
DUE TO															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Wicomico		(State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Earl L. Royer, M.D.		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) Earl L. Royer, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-6-67		23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellow		23d. LOCATION (City or Town) Wetipquin		(County) Wicomico							
24. FUNERAL DIRECTOR Jolley Funeral Home, Salisbury, Md.		ADDRESS				25a. REC'D BY REGISTRAR Charles Judge		(State) Md.							
B62						DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

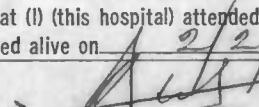
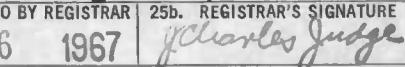
02863

CERTIFICATE OF DEATH

02855

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1 D 2/1/67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First PAULINE KATHERINE	Middle CULVER	Last 4. DATE OF DEATH February 2 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unk.) Feuse		14. MOTHER'S MAIDEN NAME Freida Ott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Wayne A. Culver (Son)		Address 226 Monticello Avenue, Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinomatosis 1538 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of colon DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mo. 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) May 1963
20f. (City or town) Salisbury	(County) Wicomico	(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 2/21/67 to 2/21/67 , that (I) (we) last saw the deceased alive on 2/21/67 , and that death occurred at 12:00 , from the causes and on the date stated above.		22b. DATE SIGNED Feb. 3 1967	
22a. SIGNATURE 		22b. DATE SIGNED Feb. 3 1967	
22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 4, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Bridgeville Cemetery	23d. LOCATION (City, town or county) (State) Bridgeville, Delaware
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR FEB 6 1967
			25b. REGISTRAR'S SIGNATURE 

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02864

CERTIFICATE OF DEATH

02856

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Worcester	
c. LENGTH OF STAY IN lb 10 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 32 Greenway Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARRY	Middle JACKSON	Lost 4. DATE OF DEATH Custis, JR. February 10 1967
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 7, 1921
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist	10b. KIND OF BUSINESS OR INDUSTRY Retail Drug	11. BIRTHPLACE (County & State, or foreign country) Somerset County, Maryland	9. AGE (In years last birthday) 45 yrs.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Jackson Custis, Sr.	14. MOTHER'S MAIDEN NAME Nellie Stanford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. WW 2	17. INFORMANT 218-10-8059	Address Mrs Beverly Custis, Pocomoke City, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 466X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. pulmonary emboli, from phlebothrombosis (b) Rt. leg -; Bilateral lower lobe pneumonia; (c) '			
INTERVAL BETWEEN ONSET AND DEATH 2-3 days.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) post-operative peritonitis, Rt. subhepatic abscess, duodenal fistula, gastric ulcer, colostomy			
19. WAS AUTOPSY PERFORMED? yes <input checked="" type="checkbox"/> no <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) '		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/13 1966 , to 2/10 1967 , that (I) (we) last saw the deceased alive on 2/10 1967 , and that death occurred at Salisbury M, fram causes and an the date stated above.			
22a. SIGNATURE William P. Sadler		22b. DATE SIGNED 2/13/67	
22c. PHYSICIAN'S NAME (Type) William P. Sadler		22d. ADDRESS Medical Center Salisbury, Wic. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-13-1967	23c. NAME OF CEMETERY OR CREMATORIUM First Baptist	23d. LOCATION (City or Town) (County) (State) Pocomoke City Wor. Md.
24. FUNERAL DIRECTOR Robert H. Watson	ADDRESS Pocomoke City, Md.	25a. REC'D BY REGISTRAR Robert H. Watson	25b. REGISTRAR'S SIGNATURE Robert H. Watson

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0300-0400Z

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film #G3852/20/67 pg

CERTIFICATE OF DEATH

02857

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02865								
1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 967 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 30 Edgewood Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Julius	Middle DARBY	Lost	4. DATE OF DEATH FEBRUARY 14 1967	Month FEBRUARY	Day 14	Year 1967
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED	8. DATE OF BIRTH 6/20/82	9. AGE (In years last birthday) Unknown 8 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Factory		11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 266-18-069A		17. INFORMANT E.K. Williams		Address # Church St Bridgeville, Del.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Acute coronary thrombosis				INTERVAL BETWEEN ONSET AND DEATH 5 min.		
(b) Arteriosclerotic cardio vascular disease DUE TO 8282 (c)						Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Lues, latent treated.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 22, 1964, to February 14, 1967, that (I) (we) last saw the deceased alive on February 14, 1967, and that death occurred at 8:40 AM, from causes and on the date stated above.								
22a. SIGNATURE C. H. Winnacott		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 2-14-67		
22c. PHYSICIAN'S NAME (Type) Dr. C. H. Winnacott		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-18-67		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery		23d. LOCATION (City or Town) Middleford Sussex Del (County) (State)		
24. FUNERAL DIRECTOR W. A. Berry Jr - Middleford, Del		ADDRESS		25a. REC'D BY REGISTRAR FEB 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		
N.E. Hendest & Sons - Bridgeville, Del.								

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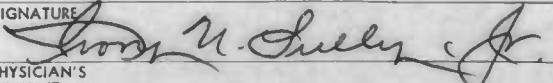
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Nicomico MARYLAND		e. STATE Maryland b. COUNTY Nicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pinensula General Hospital		d. STREET ADDRESS 683 Fitzwater St.	
3. NAME OF DECEASED (Type or print) Clayton Dashield (Deshields)		4. DATE OF DEATH Feb. 10 1967	
3. NAME OF DECEASED (Type or print) Clayton Dashield (Deshields)	First C. Middle Last 	Month Feb. Day 10 Year 1967	
5. SEX M	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 4 1890
			9. AGE (in years last birthday) 76 yrs.
			IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Sarah Dashield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) Yes H.W.I.		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT Fulton Dashield R.F.D.1 Hebron Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. 4201			
(b) DUE TO Hypertensive Cardiovascular Disease		37 Years	
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Ivory U. Sully Jr. attended the deceased from 4/6/63 , 19 PM to 2/1/67 , 19 , that (I) last saw the deceased alive on 2/1/67 , 19 , and that death occurred at 2:15 PM , from the causes and on the date stated above.		22b. DATE SIGNED 2/14/67	
22a. SIGNATURE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD		22d. ADDRESS P. O. Box 126, Berlin, Md. 21811	
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/1967	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Green Acres		23d. LOCATION (City, town or county) (State) Salisbury Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart Salis. and.		25a. REC'D BY REGISTRAR DATE FEB 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Alfred Šimánek

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02867

CERTIFICATE OF DEATH

02859

1. PLACE OF DEATH a. COUNTY So Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.	b. COUNTY Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville	d. STREET ADDRESS Jesterville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First JOHN	Middle W.	Last DASHIELLS	4. DATE OF DEATH 2/4/67	Month Feb.	Day 4	Year 1967
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5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Apr. 10, 1880	9. AGE (in years last birthday) 86 yrs.	F UNDER 1 YEAR Months	F UNDER 24 HRS. Days	Hours Hours	Min. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Jesterville Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME Dore Baily	14. MOTHER'S MAIDEN NAME Unknown	Address Nathaniel Dashielis
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 210-20-7865	17. INFORMANT Unknown	Address Nathaniel Dashielis
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO Aduen carcinoma Prostate	DUE TO Generalized Adenosclerosis	Year Sev. year
(b)			
(c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Atheros - several years				

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Jan. 19 1967	20d. INJURY OCCURRED While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At home	20f. (City or town) Jonestown	(County) Salisbury	(State) Maryland
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21. I certify that (I) (this hospital) attended the deceased from Jan. 24 , 1967, to Feb. 4 , 1967, that (I) (we) last saw the deceased alive on Jan. 24 , 1967, and that death occurred at 359 M, from the causes and on the date stated above.	22b. DATE SIGNED 2/16/67
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22a. SIGNATURE G. Herbert Semby	22b. DATE SIGNED 2/16/67
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22c. PHYSICIAN'S NAME (Type) G. Herbert Semby	22d. ADDRESS Salisbury Maryland
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/8/67	23c. NAME OF CEMETERY OR CREMATORIAL Ezkeys Cemetery	23d. LOCATION (CITY, town or county) Jonestown	(State) Maryland
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24. FUNERAL DIRECTOR Anthony E. Wara Crisfield Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE MD.
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12261

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02868

CERTIFICATE OF DEATH

02860

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS Rt. #1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Rt. #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DONALD		First FRANCIS	Middle DUNNOCK	Last	4. DATE OF DEATH March 15, 1893	Month 2	Day 27	Year 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1893	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (County & State, or foreign country) Maryland, Dorchester		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Matthias M. Dunnock				14. MOTHER'S MAIDEN NAME Virginia Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-38-1081		17. INFORMANT Mrs. Helen S. Dunnock, Sec 2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> DUE TO <i>Carcinoma of lung</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-21 , 19 67 to 2-21 , 19 67 , that (I) (we) last saw the deceased alive on 2-21 , 19 67 , and that death occurred at 3:10A M, from causes and on the date stated above.									
22a. SIGNATURE <i>Wilber R. Ellis Jr.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wilber R. Ellis, Jr., M.D.		22d. ADDRESS Medical Center, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-1-1967		23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR Hill Funeral Home		ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE MAR 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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2008-09

FOR STATE
HEALTH DEPT.

02869

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02861

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 804 E. Church Street		d. STREET ADDRESS 804 E. Church Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN WILLIAM ELLIOTT, SR.		First JOHN	Middle WILLIAM
Last ELLIOTT, SR.	DATE OF DEATH February 18 1967	Month February	Day 18
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH May 25, 1905
9. AGE (In years last birthday) 61 yrs.	10. KIND OF BUSINESS OR INDUSTRY Window Cleaning Serv. Salisbury, Maryland	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME A. Lee Elliott	14. MOTHER'S MAIDEN NAME Mary Wright	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 159-03-2050		17. INFORMANT Mrs. Rada C. Elliott (Wife)	Address 804 E. Church Street, Salisbury, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. Earl L. Royer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	22. DATE SIGNED February 21 1967
EXAMINER'S NAME (Type) Dr. Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.	23. LOCATION (City or Town) (County) (State) Wicomico County, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 21, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cemetery
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR Charles J. Judge
			25b. REGISTRAR'S SIGNATURE Charles J. Judge

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12250

F. L. H.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02870

CERTIFICATE OF DEATH

Item #8 & 9 Film C286 2/20/67

02852

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b d. STREET ADDRESS Peninsula General Hospital Helenon, md.	
c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura		First Laura	Middle Lost EVANS
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Factory	
11. BIRTHPLACE (County & State, or foreign country) Sept. 5 1966		9. AGE (In years at time of death) 55	10. IF UNDER 1 YEAR Months 55
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME Lucretia	14. MOTHER'S MAIDEN NAME ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Lucretia Evans. Accomac, Va.	18. Address Lucretia Evans. Accomac, Va.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Convulsion DUE TO sudden HH3X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) KCVD Disease DUE TO Unknown stating the underlying cause (c) Uremic Colitis DUE TO 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Typhlocephalus 1 month old			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jan. 22, 1967 to Jan. 22, 1967		21. I certify that (I) (this hospital) attended the deceased from Jan. 22, 1967 to Jan. 22, 1967 , that (I) (we) last saw the deceased alive on Jan. 23, 1967 , and that death occurred at 1075 M from causes and on the date stated above.	
22o. SIGNATURE G. Herbert Sembley		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 2/26/67
22c. PHYSICIAN'S NAME (Type) G. Herbert Sembley		22d. ADDRESS 409 E Church St.	23d. LOCATION (City or town) (County) (State) Accomac, Accomac, Va.
23o. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-5-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Accomac
24. FUNERAL DIRECTOR Samuel Savage - New Church, Va.		25o. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02871		CERTIFICATE OF DEATH		02863	
1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANOKIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydia C. Fontaine		First	Middle	Lost	4. DATE OF DEATH Month February 16 1967
5. SEX Female		6. COLOR OR RACE White		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH JAN. 16, 1875		9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ALBANY, N.Y.	
13. FATHER'S NAME JOHN CHAMBERLIN		14. MOTHER'S MAIDEN NAME CHRISTINA ROCKEFELLER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-52-8939		17. INFORMANT Address MISS VIRGINIA FONTAINE MANOKIN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO deceased relative heart disease INTERVAL BETWEEN ONSET AND DEATH		(b) _____		(c) _____	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause stating the underlying cause lost. {		DUE TO		{	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 2-16-67 (County) 1967 (State)					
21. I certify that (I) (this hospital) attended the deceased from 2-10 , 19 67 , to 2-16 , 19 67 , that (I) (we) lost saw the deceased alive on 2-16-67 , and that death occurred at 7P M, from causes and on the date stated above.					
22a. SIGNATURE Levin R. Wilson		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-17-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/19/1967		23c. NAME OF CEMETERY OR CREMATORIAL MANOKIN PRES. CEMETERY PRINCESS ANNE, MD.	
23d. LOCATION (City or Town) PRINCESS ANNE, MD. (County) PRINCESS ANNE, MD. (State)		23e. REC'D BY REGISTRAR Charles Judge		23b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR LEVIN R. WILSON		ADDRESS PRINCESS ANNE, MD.		DATE FEB 21 1967	

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2020-09-06

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02861

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DeLmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS R.D. 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANCY		First S.	Middle Name FRANKLIN
4. DATE OF DEATH 2-10-67		Month 2	Day 19
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-11-34
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Shortt		14. MOTHER'S MAIDEN NAME Ethel Dickel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Jesse Shortt, Snow Hill, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Intestinal obstruction months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Nutrol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1409 Camden Ave., Salisbury, Md.	
22. DATE SIGNED February 13, 1967			
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial		23b. DATE THEREOF Feb. 13, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Spence Baptist
24. FUNERAL DIRECTOR Dennis Funeral Home, Snow Hill, Md.		ADDRESS	23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 15 1967 Charles Jester	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02873

CERTIFICATE OF DEATH

02865

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown		d. STREET ADDRESS R.F.D.L Mardela Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) WILBERT Mc KINLEY GAINES		First	Middle	Last	4. DATE OF DEATH Month FEBRUARY 15 1967		Doy	Year	
S. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH May 20, 1902	9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	Hours 0	Min. 0	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harrison Gains				14. MOTHER'S MAIDEN NAME Martie Truitt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-8469		17. INFORMANT Martena Gaines R.F.D.L Mardela Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>4200</i>		<i>Arteriosclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO							
{ DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Gangrene right lower leg</i>									
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1/25 1967		20f. (City or town) (County) (State) 2/15 1967			
21. I certify that (I) (this hospital) attended the deceased from 1/25 1967 to 2/15 1967 , that (I) (we) last saw the deceased alive on 2/15 1967 , and that death occurred at 10A.M. from causes and on the date stated above.									
22. SIGNATURE <i>Alfred J. Silvers</i>						22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Zion Methodist		23d. LOCATION (City or Town) (County) (State) Sharptown Md.			
24. FUNERAL DIRECTOR <i>Clinton E. Stewart Salisbury</i>						25a. REC'D. BY REGISTRAR FEB 23 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 20 M 1/66									

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

02874

CERTIFICATE OF DEATH

02866

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb Adm. in 1 D 1/7/67		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS Mardela		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle ALLEN	Lost	4. DATE OF DEATH Month FEBRUARY 3 1967	Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Oct. 1, 1896	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Hebron, Maryland	IF UNDER 24 HRS. Days 2
13. FATHER'S NAME James E. Gambrill			14. MOTHER'S MAIDEN NAME Martha Ellen Dashields		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Minnie E. Gambrill (Wife) Address Mardela Springs, Maryland	
Yes War I					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia INTERVAL BETWEEN ONSET AND DEATH 2043					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 4 mos.					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 4 mos.					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 4 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic obstructive airway disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> MEDICAL CERTIFICATION OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mardela	(County) (State) Maryland
21. I certify that (I) (this hospital) attended the deceased from Oct. 25, 1960 to Feb. 3, 1967 that (I) (we) last saw the deceased alive on February 2, 1967 , and that death occurred at 10 AM M, from causes and on the date stated above.					
22o. SIGNATURE Thomas P. Bigbee					
22c. PHYSICIAN'S NAME (Type) Dr. Thomas P. Bigbee		22b. DATE SIGNED Feb. 3 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 6, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Mardela Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Mardela, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 6 1967	25b. REGISTRAR'S SIGNATURE Charles J. ...	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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02875

CERTIFICATE OF DEATH

02867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS San Domingo			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		Firs ^t	Middle	Lost	4. DATE OF DEATH	Month	Doy Year
Lettie		Geneva	GLAZE	FEBRUARY 7 1967			
S. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Dys Hours Min.
Female	Negro			June 25, 1912	54		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer - Marvin Package Company		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Sharptown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Stanley				14. MOTHER'S MAIDEN NAME Bessie Cook			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		222-12-1421		Dora M. Winfield, Wilmington, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				INTERVAL BETWEEN ONSET AND DEATH 18 Days			
443X Cerebrovascular Accident							
DUE TO (b) HTASCVD				Curb.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/23 , 19 67 , to 2/7 , 19 67 , that (I) (we) last saw the deceased alive on 2/7 19 67 , and that death occurred at 4 AM , from causes and on the date stated above.							
22a. SIGNATURE George H. Henning				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 11, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Zion Church Cemetery		23d. LOCATION (City or Town) (County) (State) Near Sharptown, Maryland	
24. FUNERAL DIRECTOR J. J. Frampum Jr.		ADDRESS Federalburg, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles George	
VR A15 (4) 20 M 1/66				DATE Feb 16 1967			

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part no. 8740-10-00000
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

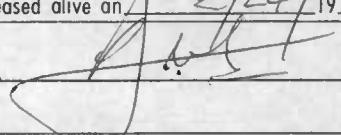
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02876

CERTIFICATE OF DEATH

02868

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb LIFETIME	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEAL ISLAND	
3. NAME OF DECEASED First WINNIE Middle		d. STREET ADDRESS MAIN ROAD	
Last HARRIS		4. DATE OF DEATH	Month February Day 25 Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 17-1880
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) CARETAKER		10b. KIND OF BUSINESS OR INDUSTRY Hunting Lodge	
10c. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JABEZ		14. MOTHER'S MAIDEN NAME LOVENIA DAYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Mrs. Virginia Owens - Princess Anne		Address MD.	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral Arteriosclerosis. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 30 hours.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus. Nephropathy + Cerebrovascular accident.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/25/67 to 2/25/67 , that (I) (we) lost saw the deceased alive on 2/24/67 and that death occurred at 4A M. , from causes and on the date stated above.		22b. DATE SIGNED 2/25/67	
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-25-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) DEAL ISLAND Som. MD.	
24. FUNERAL DIRECTOR Zeroy Webster - Princess Anne		25a. REC'D BY REGISTRAR 2nd	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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02877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02869

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital D.O.A.		d. STREET ADDRESS Parker Ave., R.D.#3	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHANNA	Middle (N.M.)	Lost
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov. 20, 1897	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR 3 Months	11. IF UNDER 24 HRS. 4 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -Chiropractor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Karl Heinrich Koch	14. MOTHER'S MAIDEN NAME Emma Kessler	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 108-03-4643	17. INFORMANT Louis Hellinger (Husband)	Address R.D.#3, Parker Ave., Salisbury, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Death	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) Dr. Earl L. Royer			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
409 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Feb. 27, 1967	23c. NAME OF CEMETERY OR CREMATORIAL J. Wm. Lee's Sons Co.
23d. LOCATION (City or Town) Washington, D. C.		(County) (State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS	25a. REC'D BY REGISTRAR FEB 28 1967
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02878

CERTIFICATE OF DEATH

02870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			b. COUNTY Worcester		
c. LENGTH OF STAY IN 1b 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS R.F.D. 2		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Willis Reynolds			First Howard	Middle Howard	Last Howard
S. SEX Male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1898	9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (County & State, or foreign country) Somerset County, Maryland	
13. FATHER'S NAME William Thomas Howard			14. MOTHER'S MAIDEN NAME Hattie Miller		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, unknown) No		16. SOCIAL SECURITY NO. 261-28-7654		17. INFORMANT Address Mrs Bertha C. Howard, Pocomoke, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b); and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease (Hemorrhage) DUE TO Art. Hemiplegia INTERVAL BETWEEN ONSET AND DEATH 4221 21 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia (c) Arteriosclerotic Cardiovascular Disease 10 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, 35 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) g			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11-218	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 2-18-67 , that (I) (we) last saw the deceased alive on 2-18-1967 , and that death occurred at 9:55 M, from causes and on the date stated above.					
22a. SIGNATURE Rufus S. Gardner Jr.			22b. DATE SIGNED 2-18-67		
22c. PHYSICIAN'S NAME (Type) Rufus S. Gardner Jr.			22d. ADDRESS MEDICAL CENTER, SALISBURY, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-21-1967		23c. NAME OF CEMETERY OR Crematory First Baptist	
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

98

- 3 -

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02879

CERTIFICATE OF DEATH

02871

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 1543 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
3. NAME OF DECEASED (Type or print) Catherine Eileen		First Catherine		Middle Eileen		Last HOWELL		4. DATE OF DEATH Month February	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1928	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Queen Anne Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John F. Baynard		14. MOTHER'S MAIDEN NAME Catherine Coleman							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-14-3456		17. INFORMANT E.J. Baynard, Easton, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningioma (Left) Frontal Lobe with surgery.		DUE TO 223X				INTERVAL BETWEEN ONSET AND DEATH 14 yrs. 6 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO 223X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from November 16, 1962 , to February 4, 1967 , that (I) (we) last saw the deceased alive on February 4, 1967 , and that death occurred at 3:33 P.M. from causes and on the date stated above.									
22a. SIGNATURE L. V. Maldive		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 2-6-67			
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Maldive		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/1967		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton, Md.			
24. FUNERAL DIRECTOR Maurice E. Neunam & Son, Easton, Md.		ADDRESS		25a. RECD BY REGISTRAR DATE FEB 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

17280

1940-46-2000

27280

1940-46-2001

8



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02880

02872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS N. Division St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Cia</i>	Middle <i>Frances</i>	Last <i>Hudson</i>	4. DATE OF DEATH Month February	Day 8	Year 1967		
S. SEX Female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/14/1891	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Saleslady		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Leonard F. Townsend			14. MOTHER'S MAIDEN NAME Jennie Carter			Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 229-18-2868		17. INFORMANT Fred Hudson Dobbs Ferry, N.Y. 10522					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>4201</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Coronary Insufficiency</i>									
DUE TO (b) <i>Coronary Insufficiency</i>									
DUE TO (c) <i></i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May , 19 66 , to Feb 8 , 19 67 , that (I) (we) lost saw the deceased alive on 2/8 19 67 , and that death occurred at 9:55 P.M. from causes and on the date stated above.									
22a. SIGNATURE <i>George H. Henning</i>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS						
23a. BURIAL, CREMATION, REBURN (check)		23b. DATE THEREOF 2/11/1967		23c. NAME OF CEMETERY OR CREMATORIALy Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR		ADDRESS <i>Chase C. Kiet - Salisbury, Md.</i>		25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02881

CERTIFICATE OF DEATH

02873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Warminster					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopsville		d. STREET ADDRESS St Martins Neck			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Noah J. Hudson		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1889	9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief of Police Retired				10b. KIND OF BUSINESS OR INDUSTRY Town Police		11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Hudson				14. MOTHER'S MAIDEN NAME Anna Burch				Address Ella Hudson - Bishopsville - Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 221-20-8742		17. INFORMANT Ella Hudson - Bishopsville - Md.		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease									
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Georgetown (County) Del. (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 14, 1967 , to Feb 20, 1967 , that (I) (we) last saw the deceased alive on Feb 20, 1967 , and that death occurred at 5:00 A.M. , from causes and on the date stated above.									
22a. SIGNATURE Donald Silmore					M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/67		23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		23d. LOCATION (City or Town) (County) (State) Georgetown - Del.			
24. FUNERAL DIRECTOR Ronald James Mellor, Del.		ADDRESS		25a. REC'D BY REGISTRAR FEB 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

37880

1130 30 MAY 1963

12250

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02882

CERTIFICATE OF DEATH

02874

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

305 N. Clairmont Drive

3. NAME OF
DECEASED
(Type or print)

ARLIE

CARTER

MIDDLE

HUGHES

LAST

R.D.#1 90A

4. DATE
OF
DEATH

February

15

1967

5. SEX

6. COLOR OR RACE

Male

White

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Dec. 20, 1908

9. AGE (In years
last birthday)

58 yrs.

IF UNDER 1 YEAR

1

IF UNDER 24 HRS.

25

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Retired-Truck Driver

Boat Const. Co.

Mahan, West Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Harvey Hughes

14. MOTHER'S MAIDEN NAME

Phoebie Powers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

400-07-7403

17. INFORMANT

Mrs. Nellie Hughes (Wife), R.D. #1 90A

Address

Nan Jemoy, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1621 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. (b)

DUE TO

(c)

Bronchogenic Carcinoma

INTERVAL BETWEEN
ONSET AND DEATH

10 months

2. MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Dermatomyositis

19. WAS AUTOPSY
PERFORMED?YES NO 20e. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

N/A

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

4-3

1969 to 2-15-1967 that (I) (we) last

saw the deceased alive on.....

2-5 1967

and that death occurred at..... 7 AM, from the causes and on the date stated above.

22e. SIGNATURE

Hubert R. White, Jr.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED
Feb. 16/196722c. PHYSICIAN'S
NAME (Type)

Dr. Hubert R. White

22d. ADDRESS

Fruitland, Maryland

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

Feb. 18, 1967

23c. NAME OF CEMETERY OR CREMATORIUM

Lewis Family Cemetery

23d. LOCATION (City, town or county)

(State)

Willards, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

HOLLOWAY & COMPANY, SALISBURY, MARYLAND

REG. REC'D BY REGISTRAR

1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

ETPSO

PLANO DE ESTUDOS

63820

DATA:

06/04/02

VOLUME:

1

AVULSOS DA FOLHA 01

VERSÃO:

ED.01 - SISTEMA

CÓPIAS: 0001

001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ABERTURA:

SON 01 - TÍTULO - FOLHA

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

ESTRUTURA DO PLANO DE ESTUDOS: 00 - TÍTULO - FOLHA 01 - 001 - 001

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02875

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 311 Locust Terrace		d. STREET ADDRESS 311 Locust Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JABE	Middle DEXTER	Last HYLTON, JR.
4. DATE OF DEATH February 20 1967	Month Year	Doy 19	Year 67
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 23, 1920		9. AGE (In years lost birthday) 46 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Laborer		11. BIRTHPLACE (State or foreign country) South Dakota	
13. FATHER'S NAME Jabe D. Hylton, Sr.		14. MOTHER'S MAIDEN NAME Ann E. Felicia Slusher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-03-5101A	
17. INFORMANT Mrs. Ann H. Disharoon (Mother)		Address 311 Locust Terrace, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH hours	
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Hypertension C.J. Disease		hours	
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20d. TIME OF INJURY Month, Day, Year Hour o.m. p.m. - 19		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		22. DATE SIGNED Feb. 22 1967	
23. ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Maryland		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
23b. DATE THEREOF Feb. 23, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11,12,13,14 Film G 386 CERTIFICATE OF DEATH

02876

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		b. COUNTY Wicomico	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Addre</i>	Middle <i>Jackson</i>	Last <i>February 12</i>
S. SEX FEMALE	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 12-05-22		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hebron, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Hayward		14. MOTHER'S MAIDEN NAME Nettie Custis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 years	
171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Co & Cx (c) Ceremia		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/24/67 , 19 67 to 2/12/1967 that (I) (we) last saw the deceased alive on 1/21/67 , 19 67 , and that death occurred at 12:40 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Heiko Baumemann</i>		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) HEIKO BAUMEMANN		22d. ADDRESS P.O. Box 15	
23a. BURIAL, CREMATION METHOD (Specify) Burial		23b. DATE THEREOF 2/15/67	
23c. NAME OF CEMETERY OR CREMATORIUM ADDRESS		23d. LOCATION (City or town) (County) (State) Hebron, Wic. Md.	
24. FUNERAL DIRECTOR Barker M. Wea, Salisbury		25a. REC'D BY REGISTRAR DATE MAR 7 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02885

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02877

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Items 18&21 Film 385 2-17 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02886

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02878

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb 5 MO.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GERALD	Middle *****	Last KING
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Pharmacy	
13. FATHER'S NAME Willard King		14. MOTHER'S MAIDEN NAME Alice Lazette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War 2		16. SOCIAL SECURITY NO. 262.24.9494	
17. INFORMANT Wife: Mrs. Glover King		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis of right kidney, severe DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pseudomonas aeruginosa XEROSEIC (c) Bronchopneumonia, bilaterally, early	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Stephan Tymkiw M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Stephan Tymkiw, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Peninsula General Hospital, Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED 2-4-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/8/67	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR J.T. STANSBERRY	ADDRESS 6411 Windsor Mill Rd.	25a. REC'D BY REGISTRAR DATE FEB 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15ME (5) 6M 1/66			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02887

CERTIFICATE OF DEATH

02879

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1 D 1/30/67				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HELEN	Middle ELIZABETH	Last LANDING			
4. DATE OF DEATH February 9 1967	Month Day Year					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 25, 1891			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 75 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Somerset County, Maryland				
12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME George Washington Basford	14. MOTHER'S MAIDEN NAME Druicilla Frances Revelle					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-48-5799	17. INFORMANT Miss Frances Landing (Daughter) R.D.#1, Cedar Lane, Salisbury, Maryland	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Berebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 days						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO generalized arteriosclerosis 5 yrs.						
	(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) degenerative heart disease - congestive heart failure						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Acco. (County) 1967 (State) 2/9	20g. (City or town) Salisbury (County) 1967 (State)
21. I certify that (I) (this hospital) attended the deceased from 1962 , and that death occurred at 9:55 A.M. from the causes and on the date stated above. P.M.	22a. SIGNATURE G. E. M. Beardsley	22b. DATE SIGNED Feb. 10/1967				
22c. PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 207 Maryland Ave., Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 12, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery	23d. LOCATION (City, town or county) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND	ADDRESS	25a. REC'D BY REGISTRAR FEB 14 1967	25b. REGISTRAR'S SIGNATURE James J. Beardsley			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02888		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						02880				
1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 1 week		c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS River Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First DANIEL	Middle J.	Last LEWIS	4. DATE OF DEATH 2-13-67		Month Year	Doy	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-1875			9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ships Master			10b. KIND OF BUSINESS OR INDUSTRY Shipping			11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Rev. Joseph Lewis				14. MOTHER'S MAIDEN NAME Sarah Whealton								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --			16. SOCIAL SECURITY NO. 180-12-3438			17. INFORMANT Mrs H. Victor Keen, Pocomoke City, Md.			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO 4231 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Advanced ASCVD										INTERVAL BETWEEN ONSET AND DEATH Minutes		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Squamous carcinoma of mouth										Years		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died during surgery for squamous carcinoma of mouth.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED February 14, 1967		
ACTUAL SIGNATURE <i>Earl L. Royer, M.D.</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Pocomoke City Wor. Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-16-1967		23c. NAME OF CEMETERY XXXXXX			23d. LOCATION (City or Town) Pocomoke City			(County) (State) Wor. Md.	
24. FUNERAL DIRECTOR Watson Funeral Home, Pocomoke, Md.			ADDRESS					25a. REC'D BY REGISTRAR DATE FEB 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02889

CERTIFICATE OF DEATH

02881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 12 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LIDA EYDA			First Alice	Middle MADDOX	4. DATE OF DEATH FEBRUARY 20 1967		
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 9, 1892	9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 0 Dots 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY ---				
11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Robert Watson			14. MOTHER'S MAIDEN NAME Mary Elizabeth Powell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None				
17. INFORMANT Miss Helen Maddox, Pocomoke City, Md.			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 days + 15 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) ---			
20f. (City or town) --- (County) --- (State) ---							
21. I certify that (I) (this hospital) attended the deceased from Feb. 19 67 to Feb 20 1967 , that (I) (we) last saw the deceased alive on Feb. 20 1967 , and that death occurred at 9:30 AM , from causes and on the date stated above.				22b. DATE SIGNED			
22a. SIGNATURE David J. Gilmore				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) David J. Gilmore, M.D.				22d. ADDRESS Medical Center, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-1967		23c. NAME OF CEMETERY OR CREMATORIUM First Baptist			
23d. LOCATION (City or Town) Pocomoke City (County) Wor. (State) Md.							
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE FEB 24 1967							

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1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02890

CERTIFICATE OF DEATH

02882

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residecne before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1 D 1/20/67			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MAY	Middle REGINA	Last MINOGUE		
4. DATE OF DEATH February 2 1967	Month Year	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1899		
9. AGE (In years last birthday) 67 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife & teacher (Retired) School	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Quinlan	14. MOTHER'S MAIDEN NAME Mary Kennedy	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No			
16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Edward A. Minogue (Husband)	Address 606 Waverly Street, Salisbury, Maryland	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema Forballe & Igardus 466X DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Phlebothrombosis (c)		
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis & Splenic Artery Thrombosis					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-31-1967 to 2-3-1967 that (I) (we) last saw the deceased alive on 2-1-1967 , and that death occurred at 8:25 AM , from the causes and on the date stated above.	22a. SIGNATURE James L. Clifford	22b. DATE SIGNED Feb. 3 1967			
22c. PHYSICIAN'S NAME (Type) Dr. James L. Clifford	22d. ADDRESS Medical Center, Salisbury, Maryland	23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 6, 1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Druid Ridge Cemetery	23d. LOCATION (City, town or county) (State) Baltimore County, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND	25a. REC'D. BY REGISTRAR FEB 6 1967	25b. REGISTRAR'S SIGNATURE James L. Clifford			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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02891

CERTIFICATE OF DEATH

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10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 203 Bay Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Audrey	Middle Mae	Last Mumford
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH JULY 31 1907
9. AGE (In years lost birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY own Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ORRIE Rogers	14. MOTHER'S MAIDEN NAME MAE HODSON	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 25-12-6171		17. INFORMANT GEORGE W. Mumford	Address BERLIN MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with chronic cox-pulmonale		INTERVAL BETWEEN ONSET AND DEATH Unknown	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) BERLIN
20f. (City or town) BERLIN		(County) MD	
(State)			
21. I certify that (I) (this hospital) attended the deceased from 2/18 , 19 67 , to 2/26 , 19 67 , that (I) (we) last saw the deceased alive on 2/26 , 19 67 , and that death occurred at 89 M, from causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED 2/28/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/1/67	23c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	23d. LOCATION (City or Town) (County) (State) BERLIN MD
24. FUNERAL DIRECTOR Hanna A. Denby Berlin Md	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
DATE FEB 28 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02884

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN Tb		d. STREET ADDRESS 516 E. Locust Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN		First ANNE	Middle MYERS
4. DATE OF DEATH February 4 1967		Month February	Day 4
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 10, 1914		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 10 Days 24 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Jacksonville, Florida
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ralph Carter	
14. MOTHER'S MAIDEN NAME (Unk.)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 541-34-5906		17. INFORMANT Mr. John E. Myers (Husband) 516 E. Locust Street, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) multiple fractures DUE TO Auto. collision Address Elm INTERVAL BETWEEN ONSET AND DEATH 24 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. 8120		(b) multiple fractures (c) multiple fractures	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) Struck by truck causing head	
20c. TIME OF INJURY Month, Day, Year 10:30 P.M. 1-11-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED February 6 1967	
ACTUAL SIGNATURE Dr. Earl L. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		Address (Street, city, town, or county) 409 Camden Avenue, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 8, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellow Cemetery
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. LOCATION (City or Town) (County) (State) Laurel, Delaware	
		25b. REC'D BY REGISTRAR DATE FEB 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

02893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02885

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		02893		2		
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		3. 02885		
a. COUNTY Wicomico		a. STATE MARYLAND		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS 348 Cedar Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) LUCILLE		First LUCILLE	Middle E.	Lost NICHOLAS	4. DATE OF DEATH 2-19-67	
S. SEX F	6. COLOR OR RACE AA	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 2-10-1912	9. AGE (In years lost birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Penns.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME Perry Dutton		14. MOTHER'S MAIDEN NAME mary w. Nichols		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		
				16. SOCIAL SECURITY NO.		
				17. INFORMANT Esther Hale - Fruitland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 DUE TO		Minutes				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		Hours				
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Salisbury	(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
		Address (Street, city, town, or county) Salisbury, Md. area				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-67	23c. NAME OF CEMETERY OR CREMATORIAL GreenAcre	23d. LOCATION (City or Town) Salisbury, Md. area	(County) Md.	(State) Md.
24. FUNERAL DIRECTOR Jolley Funeral Home, Salisbury, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE	
				DATE FEB 28 1967		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02894

CERTIFICATE OF DEATH

02886

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 3 Wks.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAMIE		First HOLLOWAY	Middle PARKER	Lost	4. DATE OF DEATH 2 Oct. 11, 1893	Month 28	Doy 19 67
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1893	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland, Wicomico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha Holloway				14. MOTHER'S MAIDEN NAME Martha Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-7952		17. INFORMANT Mrs. Thomas Mumford, Sec. 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 466X DUE TO Pulmonary Embolus INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Phlebothrombosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Idiopathic Thrombocytopenic Purpura							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from Feb. 8, 1967 to Feb 28, 1967 , that (I) never last saw the deceased alive on Feb 28, 1967 , and that death occurred at 1238 M. from causes and on the date stated above.							
22a. SIGNATURE Thomas C. Hill Jr.							
22c. PHYSICIAN'S NAME (Type) Thomas C. Hill Jr.		22d. ADDRESS Pine Bluff Road, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-1967		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR Hill Funeral Home				ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE MAR 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02895

CERTIFICATE OF DEATH

02887

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 2 days		b. COUNTY Dorchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Taylor Avenue						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)	First Velma	Middle Herelia	Last Payne	4. DATE OF DEATH Month February	Day 1	Year 1967				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1907	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Doys 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (County & State, or foreign country) Caroline Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Minos Cohee				14. MOTHER'S MAIDEN NAME Katie Robinson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 214-07-8649			17. INFORMANT Mrs. Charlotte Hearne, Secretary, Maryland			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atrial fibrillation. DUE TO 4331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1967 , to Feb 1, 1967 that (II) (we) lost saw the deceased alive on Feb 1, 1967 and that death occurred on Feb 1, 1967 M, from causes and on the date stated above.										
22a. SIGNATURE Younger Moon										22b. DATE SIGNED Feb 1, 1967
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 4, 1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Zion Cemetery			23d. LOCATION (City or Town) (County) (State) Near Williamsburg, Maryland			
24. FUNERAL DIRECTOR J. B. Frampton and Son		ADDRESS Federalsburg, Maryland		25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02896

CERTIFICATE OF DEATH

02888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PITTSVILLE		d. STREET ADDRESS RT.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS RT.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Lelia	Middle Sackson	Last Pennwell	4. DATE OF DEATH	Month FebrUARY	Day 4	Year 1967				
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 2, 1883	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days Hours Min.				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Parsonsbridge MD		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME GEORGE EDWARD JACKSON		14. MOTHER'S MAIDEN NAME SARAH RICHARDSON		Address							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-20-4059		17. INFORMANT Mrs Ruth Jones Pittsville MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage					
MEDICAL CERTIFICATION		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X		DUE TO (b)		DUE TO (c)					
								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2-3, 1967 to 2-4, 1967 that (I) (we) last saw the deceased alive on 2-4, 1967 , and that death occurred at Pittsville MD , from causes and on the date stated above.											
22a. SIGNATURE Les Bellotte		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-4-67							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/7/67		23c. NAME OF CEMETERY OR CREMATORIAL Pittsville Wic. MD		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Annie A. Burbage Belair Md		ADDRESS		25a. REC'D BY REGISTRAR FEB 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

288-81

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CATALOGUE

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02897

CERTIFICATE OF DEATH

02889

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 700 E. Church Street							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First CRESTON	Middle ARRILUS (RILL)	Last Pollitt	4. DATE OF DEATH February 3		Month February	Doy 3	Year 1967		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1877		9. AGE (In years last birthday) 89 yrs.		10. UNDER 1 YEAR 2 Months 11. IF UNDER 24 HRS 28 Days Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland			
13. FATHER'S NAME Joshua D. Pollitt				14. MOTHER'S MAIDEN NAME Charlotte Ellen Maddox				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-26-4408 A				17. INFORMANT Mrs. Irma Kieffer &/or Mrs. Naomi Long, Salisbury, Maryland Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH <i>of days</i>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction											
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary artery disease											
DUE TO (c) not known											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) N/A							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1206 67		20f. (City or town) Salisbury (County) Wicomico (State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 1/20/67 to 2/3/67 that (I) (we) last saw the deceased alive on 2/3/67 , and that death occurred at 7:30 PM , from causes and on the date stated above.				22a. SIGNATURE <i>J. J. Burton</i>				22b. DATE SIGNED Feb. 3/1967			
22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton				22d. ADDRESS Medical Center, Salisbury, Maryland				22e. REC'D BY REGISTRAR FEB 6 1967		22f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 6, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		23d. LOCATION (City or Town) Salisbury (County) Wicomico (State) Maryland		25a. REC'D BY REGISTRAR FEB 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				ADDRESS				DATE			

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CEESO

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02898

CERTIFICATE OF DEATH

02890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden #1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Meadow Bridge Rd.,			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle —	Lost —	4. DATE OF DEATH RAYMOND	Month FEBRUARY	Day 7	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1873	9. AGE (In years last birthday) 94 yrs.	10. IF UNDER 1 YEAR Months DAYS	11. IF UNDER 24-HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Raymond				14. MOTHER'S MAIDEN NAME Unknown Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. John Raymond Grace St. Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH One year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Viral Encephalitis 2 weeks last. (c) DUE TO Dehydration Second day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Eden	(County) Wicomico	(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1966 to Feb. 7, 1967 , that (I) (we) last saw the deceased alive on Feb. 3, 1967 , and that death occurred at 27 M, from causes and on the date stated above.							
22a. SIGNATURE G. Herbert Semblly		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/7/67		
22c. PHYSICIAN'S NAME (Type) G. Herbert Semblly		22d. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-1967	23c. NAME OF CEMETERY OR CREMATORIAL Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Eden, Wicomico, Maryland		
24. FUNERAL DIRECTOR Hill Funeral Home				ADDRESS Salisbury, Maryland	25a. REC'D BY REGISTRAR DATE FEB 14 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02899

CERTIFICATE OF DEATH

02891

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE				
Wicomico MARYLAND		Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 3 days.				
Salisbury		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico Nursing Home				
3. NAME OF DECEASED (Type or print)		First Payne	Middle Vilthe			
Last Arlene		4. DATE OF DEATH February 3 1967				
5. SEX F		6. COLOR OR RACE W	7. MARRIED WIDOWED	8. DATE OF BIRTH 8/25/88	9. AGE (In years last birthday) 78 yrs.	10. UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jackson Lee Dennis		14. MOTHER'S MAIDEN NAME Annie Jane Powell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X		16. SOCIAL SECURITY NO. 212-10-9101		17. INFORMANT Alvin Dennis Willonds, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Cerebral Thrombosis Cerebral Arteriosclerosis		
INTERVAL BETWEEN ONSET AND DEATH 6 weeks						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Willonds	(County) Md.	(State)
19						
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1967, to Feb. 3, 1967, that (I) (we) last saw the deceased alive on Feb. 3, 1967, and that death occurred at 20 M, from the causes and on the date stated above.						
22a. SIGNATURE John Johnson		22b. DATE SIGNED Feb. 3, 1967				
22c. PHYSICIAN'S NAME (Type)		M.D. <input type="checkbox"/> ATTENDING PHYS.	MED. <input type="checkbox"/> DIRECTOR	STAFF <input type="checkbox"/> PHYS.		
		22d. ADDRESS				

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/6/67	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant	23d. LOCATION (City, town or county) Willonds, Md.	(State)
24. FUNERAL DIRECTOR ADDRESS Tito Whaley Selbyville, Del.			25a. REC'D BY REGISTRAR DATE FEB 8 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

12250

HOLY NAME OF JESUS

68330

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02900

CERTIFICATE OF DEATH

02892

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
c. LENGTH OF STAY IN lb 304 lbs				d. STREET ADDRESS 301 Maryland Ave.,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 Maryland Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Mollie	Middle Driscoll	Lost Rayne	4. DATE OF DEATH 2	Month 27	Doy Year 1967	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1897	9. AGE (In years lost birthday) yrs. 89	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Wicomico-Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Driscoll				14. MOTHER'S MAIDEN NAME Ada Gertrude Evans				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 220-32-1232		17. INFORMANT S.W. Rayne, Jr			Address Salisbury, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarction								INTERVAL BETWEEN ONSET AND DEATH
4201 DUE TO (b) Congestive Heart Failure								1 mo
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) DUE TO (c) Atherosclerotic Cardiovascular Disease								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Constipation - acute								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2-23 , 19 67 , to 2-27 , 19 67 , that (I) (we) last saw the deceased alive on 2-23 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above.								
22. SIGNATURE Thomas P. Bigbee								22b. DATE SIGNED 2-27-67
22c. PHYSICIAN'S NAME (Type) Thomas P. Bigbee				22d. ADDRESS 211 Maryland Ave., Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/2/1967	23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland			
24. FUNERAL DIRECTOR Hill Funeral Home				ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20 M 1/68				DATE MAR 1 1967				

SECRET

REF ID: A62010 3020080

SECRET

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G386 37767 mh

CERTIFICATE OF DEATH

02893

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Saxis		d. STREET ADDRESS Saxis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Minnie	Middle C	Last Rhodes	4. DATE OF DEATH February 23 1967	Month February	Day 23	Year 1967
S. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 21 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Accomack Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter W. Ponnwell		14. MOTHER'S MAIDEN NAME Amanda Lewis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Anterose Myocardial Infarction, L. V. INTERVAL BETWEEN ONSET AND DEATH 19 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemopericardium (c) Occlusive Descending Coronary artery Left Anteroseptal Myocardial Infarction, L. V. Occlusive Descending Coronary artery Left Anteroseptal Myocardial Infarction, L. V.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cephal, Renal							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at 5		20f. (City or town) (County) (State) 2123	
21. I certify that (I) (this hospital) attended the deceased from 2/23 1967 to 2/23 1967 , that (I) (we) last saw the deceased alive on 2/23 1967 , and that death occurred at 4:20 P.M. from causes and on the date stated above.							
22a. SIGNATURE Rufus S. Gardner Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/24/67			
22c. PHYSICIAN'S NAME (Type) Rufus S. Gardner Jr.		22d. ADDRESS MEDICAL CENTER, SALISBURY MD					
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-67		23c. NAME OF CEMETERY OR CREMATORIAL Drewer		23d. LOCATION (City or Town) (County) (State) Saxis - Accomack Co.	
24. FUNERAL DIRECTOR James N. Tat		ADDRESS Temperanceville, Va		25a. REC'D BY REGISTRAR DATE MAR 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02902

CERTIFICATE OF DEATH

02894

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>1 day.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bushaperville</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <u>KATIE</u>	Middle <u>Rick</u>	Last <u>KAROS</u>	4. DATE OF DEATH	Month <u>FEBRUARY</u>	Doy <u>23</u>	Year <u>1967</u>				
S. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1875</u>	9. AGE (In years on birthday) <u>91</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Dys <u>0</u>	Hours <u>0</u>	Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>A.S.A.</u>					
13. FATHER'S NAME <u>James Smith</u>		14. MOTHER'S MAIDEN NAME <u>Martha Murray</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>214-36-5083</u>		17. INFORMANT <u>Raymond Hudson Bushaperville Md.</u>		Address <u>301</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO <u>Arteriosclerotic coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Hyperthyroid Disease</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>—</u>									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u>		(County) <u>—</u>		(State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/23/67</u> to <u>2/27/67</u> , 1967, that (I) (we) last saw the deceased alive on <u>2/23/67</u> , 1967, and that death occurred at <u>2/27/67</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Jane</u>										22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>—</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2/26/67</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Looff</u>		23d. LOCATION (City or Town) <u>Bushaperville, Md.</u>		(County) <u>—</u>		(State) <u>—</u>	
24. FUNERAL DIRECTOR <u>Toler Whaley Bushaperville, Del.</u>		ADDRESS <u>—</u>		25a. REC'D BY REGISTRAR <u>Charles J. Gause</u>		25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>FEB 27 1967</u>			

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Conklin, Arizona - Item 1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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02903

CERTIFICATE OF DEATH

02895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First John	Middle D.	Last RIDGWAY	4. DATE OF DEATH Month FEBRUARY 18 1967
5. SEX MALE		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 7/24/1899	9. AGE (In years lost birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BUILDER			10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		
11. BIRTHPLACE (County & State, or foreign country) WESTCHESTER, PA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN W. RIDGWAY			14. MOTHER'S MAIDEN NAME BESSIE PASSMORE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 165-28-9810A		17. INFORMANT Address MRS LILLIAN RIDGWAY PRINCESS ANNE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease (c) cardiac					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-10, 1967 to 2-18, 1967 , that (I) (we) last saw the deceased alive on 2-18, 1967 , and that death occurred at 80 M, from causes and on the date stated above.					
22a. SIGNATURE Levin R. Wilson			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-18-67	
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/22/1967	23c. NAME OF CEMETERY OR CREMATORIAL HIGHLAND MEMORIAL PARK POTTSTOWN, PA.	23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.			ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

388

20830

Section 35.000 - Definitions

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

02904

CERTIFICATE OF DEATH

02896

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one year.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ATLANTIC	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Box #139	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ellen	Middle Mae	Last ROGERS
4. DATE OF DEATH	Month FEBRUARY	Day 24	Year 1967
S. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Nov. 22, 1906	9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR Months 3 Days 2	IF UNDER 24 HRS. Hours 19 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORK	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Salisbury, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gerald Rogers	14. MOTHER'S MAIDEN NAME BETTY TROUT	Address Box #139	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Gerald Rogers, ATLANTIC, VA.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration DUE TO Dehydration and Anemia INTERVAL BETWEEN ONSET AND DEATH Approx. 1 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dehydration and Anemia (c) Dehydration, oral, acute 3 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 2/23/1967 to 2/24/1967 , that (1) (we) last saw the deceased alive on 2/24/1967 , and that death occurred at 1/2 M. from causes and on the date stated above.			
22a. SIGNATURE Alfred S. Koles		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Alfred S. Koles		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/26/1967	23c. NAME OF CEMETERY OR CREMATORIUM Christian	23d. LOCATION (City or Town) (County) (State) Snow Hill, MO.
24. FUNERAL DIRECTOR Guard Caskets	ADDRESS Snow Hill, MO.	25a. REC'D BY REGISTRAR DATE FEB 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

02905

CERTIFICATE OF DEATH

02897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN b Adm. in 1 D 2/8/67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAYMOND		First SMUEL	Middle Smack, Sr.
		Lost FEBRUARY 21	4. DATE OF DEATH Month 1967
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 1, 1913
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Roads Comm.	
11. BIRTHPLACE (County & State, or foreign country) Worcester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Smack		14. MOTHER'S MAIDEN NAME Susan Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO. 220-36-8229	
17. INFORMANT Mrs. Norma Lee Smack (Wife)		Address 511 Regency Drive, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
4201 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. } DUE TO (b) Arteriosclerotic Heart Disease } DUE TO (c) Hypertension and Diabetes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) was attended the deceased from Feb 8, 1967 to Feb 21, 1967 , that (I) was last saw the deceased alive on Feb 20, 1967 , and that death occurred at 7:51 AM , from causes and on the date stated above.		22b. DATE SIGNED Feb 21, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill, Jr.		22d. ADDRESS Pine Bluff Rd., SALISBURY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Nelson Cemetery		23d. LOCATION (City or Town) (County) (State) Accomac Co., Virginia	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. RECEIVED BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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to success

in your life

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

02906

CERTIFICATE OF DEATH

02898

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		d. STREET ADDRESS Washington St.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MARY		First V	Middle SMITH	Lost Feb. 27	4. DATE OF DEATH Feb. 27	Month 19 67	Day 19	Year 67		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED Divorced	B. DATE OF BIRTH Mar. 13, 1886	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 3235	IF UNDER 24 HRS. Days Faiesta	Hours La Crescenza		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Elijah Perdue				14. MOTHER'S MAIDEN NAME Margaret Sturgis						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-6779		17. INFORMANT Mrs. Virginia M. Seipp		Address 3235 Faiesta				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 332X		IMMEDIATE CAUSE (a) Thrombosis		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONS AND DEATH day				
(b)				DUE TO						
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Snow Hill, Md.		(County) Md.	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 2/21/67 to 2/21/67 , that (I) (we) last saw the deceased alive on 2/26/67 and that death occurred at 5A M. from causes and on the date stated above.										
22. SIGNATURE Earl M. Beardsley		M.D. <input type="checkbox"/> ATTENDING PHYS. Earl M. Beardsley		MED. DIRECTOR <input type="checkbox"/> None		STAFF PHYS. <input type="checkbox"/> None		22b. DATE SIGNED 2/27/67		
22c. PHYSICIAN'S NAME (Type) Earl M. Beardsley		22d. ADDRESS Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/1/1967		23c. NAME OF CEMETERY All Hallows Episcopal		23d. LOCATION (City or Town) Snow Hill, Md.		(County) Md.	(State) Md.	
24. FUNERAL DIRECTOR James Hyman		ADDRESS Snow Hill, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02907

CERTIFICATE OF DEATH

02899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19	
PLACE OF DEATH a. COUNTY		USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
Wicomico MARYLAND		Maryland		Salisbury		Salisbury		15 Calhoun Avenue																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS		f. DATE OF DEATH		Month		Day		Year																							
Salisbury				Peninsula General Hospital		15 Calhoun Avenue		February 14		1967																											
3. NAME OF DECEASED (Type or print)		First MIDDLE		Last		4. DATE OF DEATH		Month		Day		Year																									
TODD STEWART SMITH						5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS																			
Male White		WIDDOWED		Baby DIVORCED		Feb. 13, 1967		4:30 PM		0 yrs.																											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?																															
none		INDUSTRY		Salisbury, Maryland		USA																															
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME																																			
Preston Randle Smith		Polly Mae Stewart																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT																																	
No				Mr. Preston R. Smith (Father) 15 Calhoun Ave., Salisbury, Maryland																																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH (1)																																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		7 hr 45																																			
7610 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Due To (b) Prolapsed cord (c) Premature separation membranes																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																																					
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A																																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																															
19																																					
21. I certify that (I) (this hospital) attended the deceased from 2/13 1967, to 2/14 1967, that (I) (we) last saw the deceased alive on 2/14 1967, and that death occurred at 12:10 P.M. from the causes and on the date stated above.																																					
22a. SIGNATURE <i>D. S. Anderson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED A.M. Feb. 16, 1967																																	
22c. PHYSICIAN'S NAME (Type) Dr. D. G. Anderson		22d. ADDRESS Medical Center, Salisbury, Maryland																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 16, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery		23d. LOCATION (City, town or county) Salisbury, Maryland (State)																															
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE 1967-02-16		25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>																															

QUEST

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GOALS

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02908

CERTIFICATE OF DEATH

02900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 408 Winder Street		d. STREET ADDRESS 408 Winder Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LESTER	Middle MARTIN	Last STEELE
4. DATE OF DEATH	Month February	Day 2	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1902
9. AGE (In years last birthday) 64 yrs.	10. KIND OF BUSINESS OR INDUSTRY Power & Light Co.	11. BIRTHPLACE (County & State, or foreign country) Lewes, Delaware	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Elmer Steele	14. MOTHER'S MAIDEN NAME Eunice Spicer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --	16. SOCIAL SECURITY NO. -----	17. INFORMANT Mrs. Bernice W. Steele (Wife)	Address 408 Winder Street, Salisbury, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 1 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19	19		
21. I certify that (I) (this hospital) attended the deceased from 1941 , 19, to 2-2-67 , 19, that (I) (we) last saw the deceased alive on 1-31-67 , 19, and that death occurred at 2 p M, from the causes and on the date stated above.			
22a. SIGNATURE Lee L. Lawry		22b. DATE SIGNED Feb. 3 /1967	
22c. PHYSICIAN'S NAME (Type) Dr. Lee L. Lawry	22d. ADDRESS 315 N. Division St., Salisbury, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 5, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND	ADDRESS	25a. REC'D BY REGISTRAR FEB 6 1967	25d. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02903

02901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Open please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE DELAWARE		b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLSBORO		d. STREET ADDRESS 1163	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JANNIE	Middle STEPHENS	Last FEBRUARY 1	4. DATE OF DEATH Month 1967	Month 19	Day 1	Year 67
S. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-19-1886	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLAYTON ATKINS		14. MOTHER'S MAIDEN NAME MARY ELIZABETH ATKINS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 222-01-7286		17. INFORMANT MRS. DALLAS HUDSON, MILLSBORO		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable pulmonary embolism						INTERVAL BETWEEN ONSET AND DEATH	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Deep ven thromb of left lower extrem					
		DUE TO (c) Anticoagulant cardiovascular disease - drug toxicity					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Suspect replacement of eye.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-12-1967 , to 2-1, 1967 , that (II) (we) last saw the deceased alive on 1-31-1967 , and that death occurred at 7th M , from causes and on the date stated above.							
22a. SIGNATURE James L. Clifford		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JAMES L. CLIFFORD		22d. ADDRESS		22b. DATE SIGNED 2-1-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-5-67		23c. NAME OF CEMETERY OR CREMATORIAL MILLSBORO CEMETERY		23d. LOCATION (City or Town) (County) (State) MILLSBORO SUSSEX DELA	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR FEB 14		25b. REGISTRAR'S SIGNATURE Charles Judge	

10020

07-20-70 070100Z

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Initial Anterior alignment

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02910

CERTIFICATE OF DEATH

02902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 432 Druid Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle F.	Last STRAN
4. DATE OF DEATH Month FEBRUARY	Day 9	Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 7-19-1892
9. AGE (In years b. birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Business	11. KIND OF BUSINESS OR INDUSTRY Retired	12. BIRTHPLACE (County & State, or foreign country) Baltimore
13. FATHER'S NAME Henry P. Stran	14. MOTHER'S MAIDEN NAME Alverda Rector	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <input type="checkbox"/> NO (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 212-07-4289	17. INFORMANT Louise Stran-432 Druid Hill Ave. Salisbury	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arthur Stran died of heart disease DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH MD	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 67 , to 2-9 , 19 67 , that (I) (we) last saw the deceased alive on 2-9 19 67 , and that death occurred at MD , fram causes and on the date stated above.			
22a. SIGNATURE Willie Q. Eason		22b. DATE SIGNED 2-9-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-13-1967	23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Elsworth Remacost		ADDRESS 4600 Liberty Hights. Avenue	25a. REC'D BY REGISTRAR DATE FEB 14 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

Section

183

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CHINESE LITERATURE

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

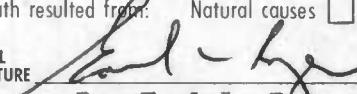
6
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
02911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02903

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS R.D. #1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JOHN	Middle SAMUEL	Last TINDLE	4. DATE OF DEATH February 2 1967	Month Year	Doy Year		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1895	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 2	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wicomico County, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert R. Tindle			14. MOTHER'S MAIDEN NAME Martha Driscoll						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No --		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Helen C. Tindle (Wife) R.D. #1, Pittsville, Maryland		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8239 DUE TO Fx Dored Spine & Severe cold Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of vehicle ran off road							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Pittsville		20f. (City or town) Pittsville (County) Wicomico (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22. DATE SIGNED February 3, 1967			
EXAMINER'S NAME (Type) Dr. Earl L. Royer 409 Camden Avenue, Salisbury, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Pittsville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 6, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Farlow Cemetery		23d. LOCATION (City or Town) (County) (State) Pittsville, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			ADDRESS			25a. REC'D. BY REGISTRAR FEB 6 1967	25b. REGISTRAR'S SIGNATURE Judge		

marked 1st hand & sing 2 hand x

base for one sketch p. marked
but not sketched x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02912

02904

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN lb

Adm. in 1 D

2/9/67

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Peninsula General Hospital

**3. NAME OF DECEASED
(Type or print)**

First

Middle

Last

GEORGE

WASHINGTON

TOWNSEND

Month
February

Day
19
Year
1967

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

August 10, 1879

9. AGE (In years last birthday)

87 yrs.

IF UNDER 1 YEAR

Months
6

IF UNDER 24 HRS.

Days
9

Hours
19

Min.
19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Huckster

11. BIRTHPLACE (County & State, or foreign country)

Worcester County, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Townsend

14. MOTHER'S MAIDEN NAME

Margaret Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-10-2126

17. INFORMANT

Mrs. Martha P. Townsend (Wife)

Address

711 Taylor Street, Salisbury, Maryland

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

4500

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Massive infarct of L. Arm
Embolus L. Arm
Arterosclerosis (widely spread)

3 MEDICAL CERTIFICATION

20c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING

OP. CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

N/A

20c. TIME OF INJURY Month, Day, Year

Hour

e.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

2/9/67

19..... to.....

2/19/67

19....., that (I) (we) last

saw the deceased alive on.....

2/18/67

19....., and that death occurred at 2:55 A.M.

from the causes and/or the date stated above.

22a. SIGNATURE

Carrie I. Hearn

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

Feb. 20/1967

22c. PHYSICIAN'S NAME (Type)

Dr. Carrie I. Hearn

22d. ADDRESS

226 N. Division Street, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Feb. 22, 1967

23c. NAME OF CEMETERY OR CREMATORIUM

Parsons Cemetery

23d. LOCATION (City, town or county)

(State)

Salisbury, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE

HOLLOWAY & COMPANY, SALISBURY, MARYLAND

ADDRESS

25e. REC'D BY REGISTRAR

25f. REGISTRAR'S SIGNATURE

DATE

FEB 21 1967

Charles J. Young

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WESB

SESQ

DAILY LOG

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02913

CERTIFICATE OF DEATH

02905

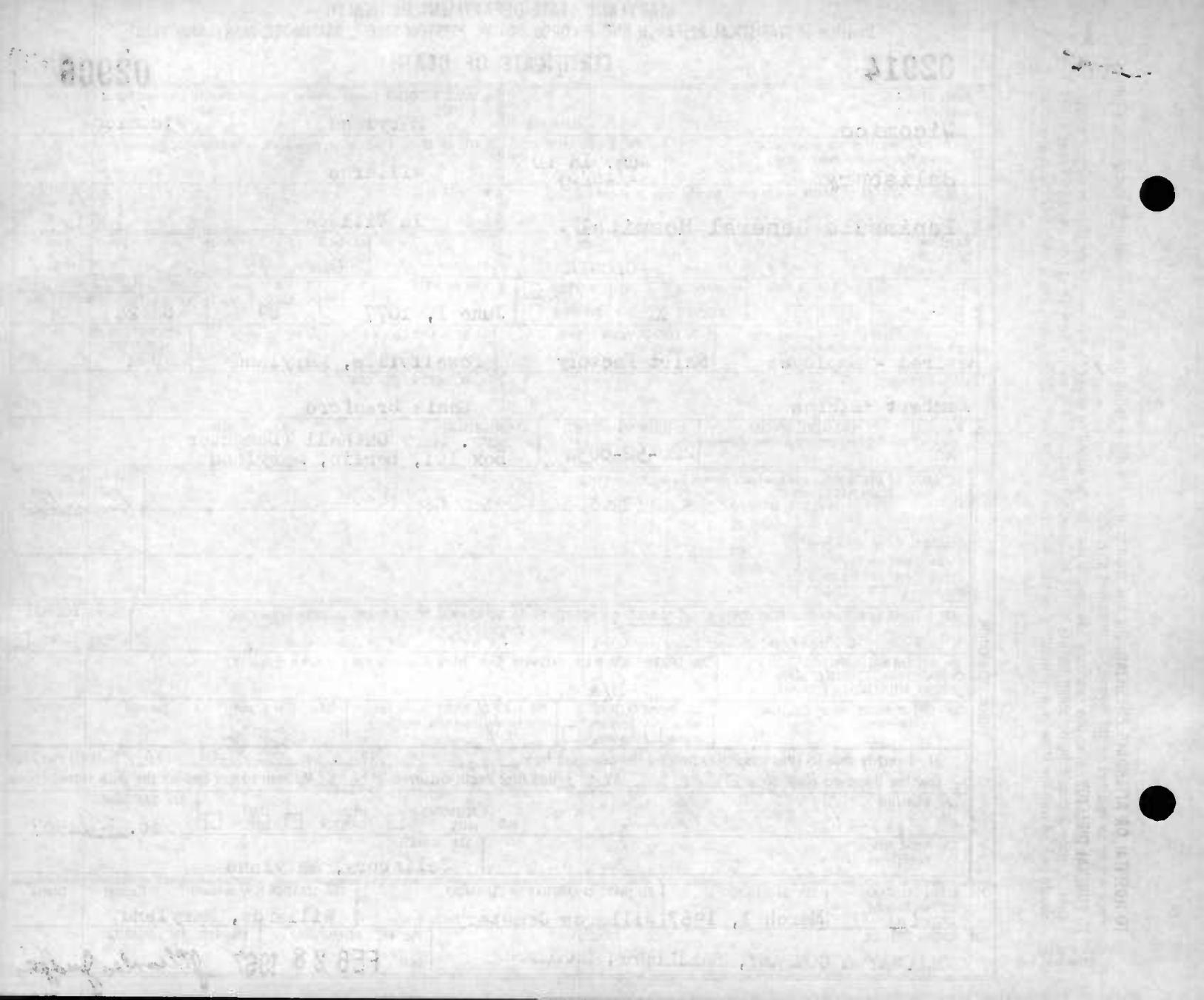
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		First W	Middle TRAVERS
4. DATE OF DEATH February 27 1967	Month February	Doy 27	Year 1967
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	
11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilbert Travers		14. MOTHER'S MAIDEN NAME Delia Travers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-6254	
17. INFORMANT Flora L. Travers, Hoopersville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
DUE TO 177X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Carcinoma of Prostate		1½ yrs.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
--			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Deer's Head State Hospital, Salisbury, Md.
20f. (City or town) Cambridge, Maryland		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 21, 1967 , to February 27, 1967 , that (I) (we) last saw the deceased alive on February 27, 1967 , and that death occurred at 1:55 P.M. from causes and on the date stated above.		22b. DATE SIGNED 2-28-67	
22a. SIGNATURE C. H. Winnacott		M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Dr. C. H. Winnacott		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/5/1967	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery
24. FUNERAL DIRECTOR Herb M. Clark Jr.		ADDRESS Cambridge, Md.	25a. REC'D BY REGISTRAR Charles Judge
			25b. REGISTRAR'S SIGNATURE Charles Judge

40850

PLATE 40 STANDARD

40850



MARYLAND STATE DEPARTMENT OF HEALTH

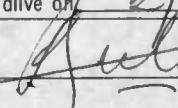
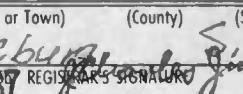
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 8 & 9 Film G386 3/1/67 kck

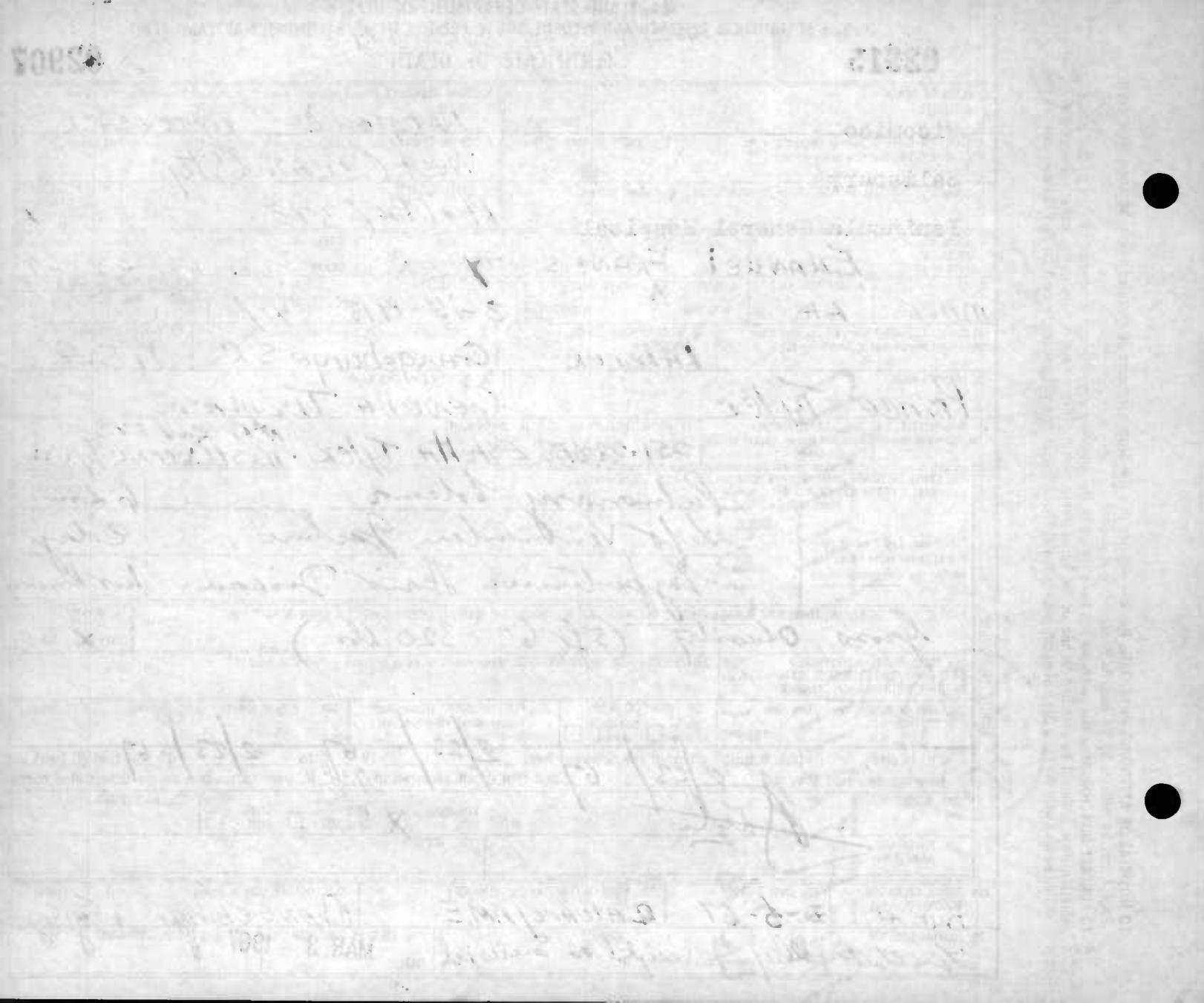
02915

CERTIFICATE OF DEATH

02907

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				b. COUNTY Worcester			
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Ocean City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Rt #4 Box 373			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First EMANUEL	Middle FRANCIS	Lost	4. DATE OF DEATH	Month FEBRUARY	Year 1967
5. SEX MALE	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 3-18-1918	9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 13	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (County & State, or foreign country) Orangeburg S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Prince Tyler				14. MOTHER'S MAIDEN NAME Geneva Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 251-28-088		17. INFORMANT Estella Tyler - West Ocean City Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 6 hours H43X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Ventricular Failure 2 day (c) Hypertensive Heart Disease not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gross Obesity (5ft 6" 320 lbs.)							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street/office bldg., etc.) 2/23/1967		20f. (City or town) (County) (State) 2/23/1967	
21. I certify that (I) (this hospital) attended the deceased from 2/23/1967 to 2/23/1967 that (I) (we) last saw the deceased alive on 2/23/1967 , and that death occurred at 2/23/1967 M, from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 2/23/1967			
22c. PHYSICIAN'S NAME (Type) Brett B. Jolley - Jersey Rd. Salisb. Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-5-67		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore J.M.E.		23d. LOCATION (City or Town) (County) (State) Orangeburg S.C.	
24. FUNERAL DIRECTOR Loretta B. Jolley - Jersey Rd. Salisb. Md.		ADDRESS		25a. RECEIVED BY REGISTRAR MAR 5 1967		REGISTRAR'S SIGNATURE 	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02916

CERTIFICATE OF DEATH

02908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
1. PLACE OF DEATH
e. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

Fruitland

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Levin

C.

Neters

5. SEX

6. COLOR OR RACE

M

C.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

B. DATE OF BIRTH

Dec. 25, 1901

9. AGE (In years
last birthday)

65 yrs.

10. BIRTHPLACE (County & State, or foreign country)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maryland

U.S.A.

13. FATHER'S NAME

Daniel Neters

Sarah Church

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

221-10-6008

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

177X

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

Hemimad

Prostate Carcinoma

INTERVAL BETWEEN
ONSET AND DEATH

1 Month

Indefinite

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? (YES NO)20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 21 Jly 1967, to 21 Jly 1967, that (I) (we) last saw the deceased alive on 21 Jly 1967, and that death occurred at 21 Jly 1967, from the causes and on the date stated above.

22e. SIGNATURE

S. Purcell

M.D.

ATTENDING PHYS. MID. DIRECTOR STAFF PHYS.

22d. ADDRESS

622 W Main St

28 Jly 1967

23e. BURIAL, CREMATION, REMOVAL (Specify)
Burial 2/25/1967

23b. DATE THEREOF

Mt. Calvary

23d. LOCATION (City, town or county)

Fruitland

(State)
Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Clinton F. Stewart Salis 2nd.

ADDRESS

25a. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE

MAR 6 1967 Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02917

02909

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and, if any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Adm. in 1 D 2/12/67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. STREET ADDRESS 304 Oak Street	
3. NAME OF DECEASED (Type or print) MARGARET (NMI) WEIMER		First Wymer	Middle W
S. SEX Female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH March 5, 1900		9. AGE (In years lost birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unk.) Weimer		14. MOTHER'S MAIDEN NAME (Unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 282-03-9050	
17. INFORMANT Sarah V. Methvin (Daughter) 304 Oak Street, Salisbury, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY DEPRESSION + ARREST		INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 170X			
DUE TO (b) CARCINOMA OF BREAST		20 months	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/12/67 , to 2/13 , 1967, that (I) (we) last saw the deceased alive on 2/13 1967 and that death occurred at 2:14 P.M. from causes and on the date stated above.		22b. DATE SIGNED 2/13/67	
22c. PHYSICIAN'S NAME (Type) B.C. Sanders		22d. ADDRESS Peninsula General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Feb. 20/1967	23c. NAME OF CEMETERY OR CREMATORIAL J. Wm. Lee's Son's Co.
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR FEB 21 1967	25b. REGISTRAR'S SIGNATURE Charles J. ...

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02910

02918

CERTIFICATE OF DEATH

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Certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. #3			d. STREET ADDRESS R.D.#3, RumRidge Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FLORENCE AMELIA WELLS			4. DATE OF DEATH Month Day Year February 3 1967		
5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH Sept. 3, 1880		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Pittsville, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Benjamin Parsons			14. MOTHER'S MAIDEN NAME Martha West		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Nicie E. Rennie (Daughter) R.D.#3, RumRidge Rd., Delmar, Md. (Deceased 19940)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH immediate		
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart disease			10 YRS		
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A		
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19			20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/28 , 1960, to 2/1 , 1967 that (I) (we) last saw the deceased alive on 2/1 , 1967, and that death occurred at 5:30 PM , from the causes and on the date stated above.			22b. DATE SIGNED Feb. 7 1967		
22a. SIGNATURE Joseph A. Elliott			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Dr. Joseph A. Elliott			22d. ADDRESS 714 West St., Laurel, Delaware		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 7, 1967		
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Farlow Cemetery			23d. LOCATION (City, town or county) (State) Pittsville, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DATE FEB 9 1967		
			25b. REGISTRAR'S SIGNATURE J Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02919

CERTIFICATE OF DEATH

02911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d. STREET ADDRESS 1207 Dorchester St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIJAH		First ---	Middle ---	Lost Whitehead	4. DATE OF DEATH February 28 1967	Month Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 27, 1907	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (County & State, or foreign country) Northampton County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Whitehead			14. MOTHER'S MAIDEN NAME Maude Richardson			Address Pocomoke, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-6094		17. INFORMANT Mrs Christine Whitehead		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of myocardium DUE TO Coronary Artery Thrombosis 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Coronary artery Thrombosis (c) Coronary artery atherosclerosis	INTERVAL BETWEEN DEATH AND DEATH 30 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 2/27, 1967, to 2/28, 1967	(County) 1967	(State) 1967
21. I certify that (I) (this hospital) attended the deceased from 2/27, 1967 , to 2/28, 1967 , that (I) (we) last saw the deceased alive on 2/28, 1967 , and that death occurred at 4P M, from causes and on the date stated above.							
22a. SIGNATURE David J. Gilmore		M.D. <input type="checkbox"/> ATTENDING PHYS. David J. Gilmore	M.D. <input checked="" type="checkbox"/> MED. DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2/28/67		
22c. PHYSICIAN'S NAME (Type) David J. Gilmore		22d. ADDRESS Medical Center, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1967	23c. NAME OF CEMETERY OR Crematory First Baptist		23d. LOCATION (City or Town) Pocomoke City Wor.	(County) Wor.	(State) Md.
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Pocomoke City, Md.	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
			DATE MAR 6 1967				

1030

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02920

CERTIFICATE OF DEATH

02912

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb Since 9/28/66		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards		d. STREET ADDRESS -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Flora	Middle Mae	Last Wilkins	4. DATE OF DEATH February	Month 9	Doy 19 67
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1892	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Tubbs				14. MOTHER'S MAIDEN NAME Margaret Truitt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-56-0351		17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardio vascular disease INTERVAL BETWEEN ONSET AND DEATH unknown 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Senility							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 28, 1966 , to Feb. 9, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 9, 1967 , and that death occurred at 8:25 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Ernest E. P. Ritchings</i>				22b. DATE SIGNED Feb. 9, 1967			
22c. PHYSICIAN'S NAME (Type) <i>Ernest E. P. Ritchings</i>		22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland 21801					
23a. BURIAL, CREMATION, OR Crematory Burial		23b. DATE THEREOF 2/12/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS New Hope		23d. LOCATION (City or Town) (County) (State) Willards Md.	
24. FUNERAL DIRECTOR Peter Whaley		ADDRESS Selbyville, Del.		25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02921

CERTIFICATE OF DEATH

02913

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Delmar Road	
3. NAME OF DECEASED (Type or print)	First MARY	Middle EVELYN	Last WILLIAMS
4. DATE OF DEATH Month February	Day 27	Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 30, 1926
9. AGE (In years last birthday) 40 yrs.	10. IF UNDER 1 YEAR 9	11. IF UNDER 24 HRS. 27	12. IF UNDER 24 HRS. Months 9 Days 27 Hours Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George T. Williams		14. MOTHER'S MAIDEN NAME Mamie Ennis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Mamie Williams (Mother)	Address Fruitland, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest			
7543 DUE TO Pulmonary Artery Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interatrial Septal Defect			
DUE TO Congenital			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Anoxia, Cyanosis			
N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 2/25/1967 to 2/27/1967 , that (I) (we) last saw the deceased alive on 2/27/1967 , and that death occurred at 3 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Rufus S. Gardner Jr.</i>		22b. DATE SIGNED Feb. 28, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rufus S. Gardner		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 2, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Smullen Cemetery	23d. LOCATION (City, town or county) (State) Worcester Co., Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
		DATE MAR 2 1967	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 4 and 5 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02922

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02914

1. PLACE OF DEATH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station		d. STREET ADDRESS Rural				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deers Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) ROBERT		First W.	Middle WINDSOR, SR.	Lost	4. DATE OF DEATH 2-20-67	Month 19	Day 19	Year		
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1901	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0		
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Wingate, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Hudson Windsor			14. MOTHER'S MAIDEN NAME Anna Frances Adams							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None			16. SOCIAL SECURITY NO. 213-18-5215		17. INFORMANT Mrs. Tressie E. Windsor, Same as 2. abcd		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Paraplegia, secondary to spinal cord lesion, lower thoracic								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boating accident		20c. TIME OF INJURY Month, Day, Year Hour o.m. PM p.m. 8-24 1966				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tangier Sound	20f. (City or town) (County) (State) Crisfield Somerset Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED February 23, 1967		
ACTUAL SIGNATURE <i>Earl L. Royer</i>		EXAMINER'S NAME (Type) Earl L. Royer, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 23, 1967		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Marion, Md.				
24. FUNERAL DIRECTOR Bradshaw Funeral Home, Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 28 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

